



Development of the Health Care Management Plan

When properly implemented by a registered nurse, the health care management plan documents the nursing process as applied to identify the health care needs of individuals served by community-based agencies contracted by the Department on Disability Services. The health care management plan includes the identified health risks, management strategies and staff training needs, including responsible parties. Each health care management plan is based upon data collected from the following sources:

- **Health Form I:** This is a record of preventative health screenings as recommended by the U.S. Preventative Health Task Force by gender, age and family risk factors. The registered nurse, in consultation with the primary care provider, documents all screenings that have been completed and notes any screenings that are appropriately deferred or declined based on the individual's needs. ***It is required that this form be present on each client's record and kept updated at all times.***
- **Health Form II:** This is a record of observations by direct support staff. At least one form should be analyzed by the R.N. in conjunction with the development of the health care management plan, but the R.N. may request input from multiple direct support staff, including staff that provide services and supports when an individual is away from their residence (e.g. supported employment setting or a day treatment program). Any item that elicits a positive response should be included in the health care management plan. ***This form is not required, but suggested for use as a systematic means of obtaining feedback on the critical observation of staff that spends the most time with an individual.***
- **Health Form III:** This document represents a chart review of medical diagnoses formulated by the primary care provider or medical specialists. Any item that elicits a positive response should be included in the health care management plan. **This form is part of the data set the registered nurse uses to develop the health care management plan, but is not part of the clinical record.**

- **Nursing Assessment:** Nursing assessment is “the deliberate and systematic collection of data to determine an individual’s current health status and to evaluate his present and past coping patterns” (Carpenito, 1987). The assessment consists of data collected through a review of records, interviews with an individual or his or her family members or support staff, a physical examination, and consultation with other professionals. The use of a structured format enables the nurse to gather consistent data on all individuals (Brown and Roth, 1994). ***The registered nurse can use a format at their discretion, but a structured format is required that will assure the registered nurse will be able to collect data sufficient to plan for an individual’s response to a real or potential problem.***

These data sources are used to formulate the health concerns listed on the health care management plan. The health concerns can be stated as nursing diagnosis. The health care management plan should also include expected outcomes for each identified health concern. This provides a target or goal that the individual and their support team can clearly understand. It also provides a measure for success.

Additional information that is required to ensure that all support staff, including those with limited literacy skills, can interpret and follow their responsibilities should be written out in separate protocols that provide expanded information about how to implement specific care strategies. All staff performing tasks delegated by the registered nurse must demonstrate competency and be able to continue to demonstrate that competency over time.

The assessment process as described is the responsibility of the registered nurse. The registered nurse can delegate specific tasks needed to maintain an individual’s health to the LPN, but only those tasks allowed by the nurse practice act.